Completing the new Adult/Adolescent HIV and AIDS Confidential Case Report Form

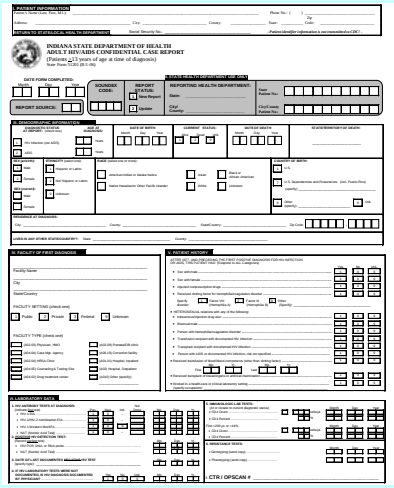
Office of Clinical Data and Research
Indiana State Department of Health
Toll free 800-376-2501 or 317-233-7406

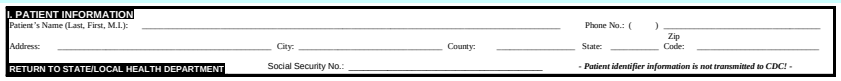
HIV/AIDS Case Report Forms

Accurate, thorough, case reports provide demographic information regarding the spread of the HIV/AIDS infection.

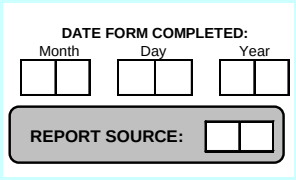
Reporting sex, race, ethnicity, and behavior allows us to to gear programs toward specific populations and areas of need.

Case reports need to be initiated within 72 hours after notifying the person they are positive. If a person does not return for their test result, send in the report at that time. All HIV-infected pregnant women must be reported immediately. All babies born to HIV-infected or AIDS-diagnosed mothers must be reported immediately after birth. Please indicate the baby's pediatrician.


INDIANA STATE DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

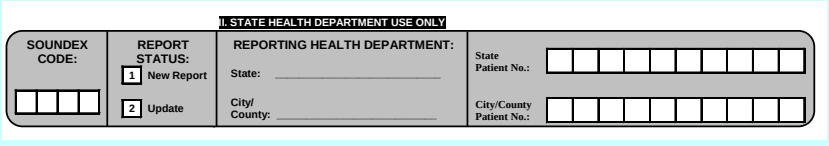


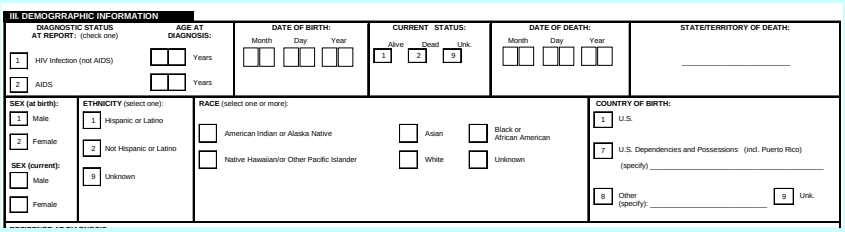
- **Print the legal name. If known, put maiden names and aliases in parentheses.**
- **For Dept of Correction inmates, include both the name and offender number. It is NOT enough to list just the offender number.**
- **Enter the social security number. It is used to make certain we have the correct person and to prevent duplication of patients.**



- **Enter the date the report is completed.**
- **ISDH will complete the report source.**

II. STATE HEALTH DEPARTMENT USE ONLY

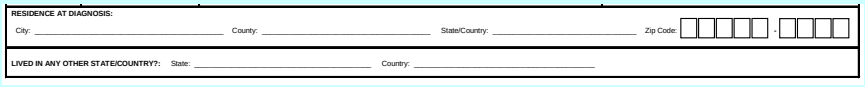



III. DEMOGRAPHIC INFORMATION

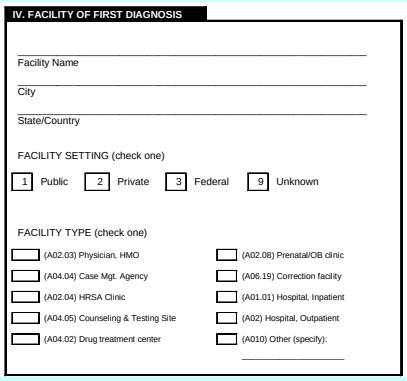
DIAGNOSTIC STATUS AT REPORT: (check one) — 1 HIV Infection (not AIDS); 2 AIDS
AGE AT DIAGNOSIS: ___ Years ___ Years
DATE OF BIRTH: Month Day Year
CURRENT STATUS: 1 Alive 2 Dead 9 Unk.
DATE OF DEATH: Month Day Year
STATE/TERRITORY OF DEATH: _____

SEX (at birth): 1 Male 2 Female
SEX (current): Male Female
ETHNICITY (select one): 1 Hispanic or Latino 2 Not Hispanic or Latino 9 Unknown
RACE (select one or more): American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian/or Other Pacific Islander; White; Unknown
COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) _____ 8 Other (specify): _____ 9 Unk.

- **Indicate whether the person is infected with HIV or has progressed to an AIDS diagnosis.**
- **Enter the date of birth correctly and legibly.**
- **Indicate if the person is alive or deceased. If deceased, enter the date of death and the state/territory where the person died.**
- **Mark the sex at birth <u>and</u> the current sex.**
- **Indicate both the ethnicity and the race(s) of the person.**
- **Complete the Country of Birth. If born outside of the United States, write in the country.**


RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/Country: _____ Zip Code: _____ - _____
LIVED IN ANY OTHER STATE/COUNTRY?: State: _____ Country: _____

- **Enter the residence at first diagnosis. <u>It may not be the patient's current address</u> – include the county, state/country if outside United States and zip code.**
- **Indicate any other states/countries where person may have lived. Enter this information even if it was prior to their diagnosis.**



IV. FACILITY OF FIRST DIAGNOSIS

Facility Name

City

State/Country

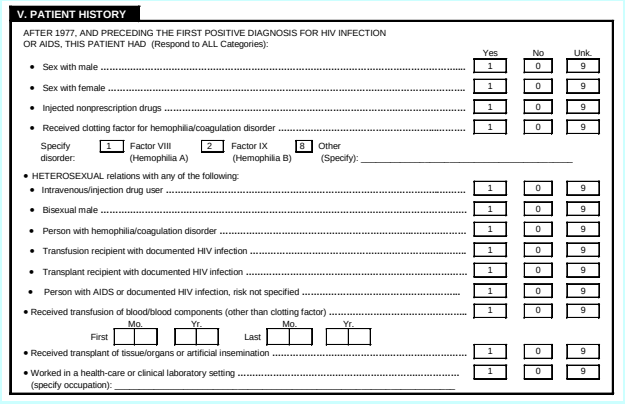
FACILITY SETTING (check one)

1 Public 2 Private 3 Federal 9 Unknown

FACILITY TYPE (check one)

- (A02.03) Physician, HMO
- (A04.04) Case Mgt. Agency
- (A02.04) HRSA Clinic
- (A04.05) Counseling & Testing Site
- (A04.02) Drug treatment center
- (A02.08) Prenatal/OB clinic
- (A06.19) Correction facility
- (A01.01) Hospital, Inpatient
- (A02) Hospital, Outpatient
- (A010) Other (specify): _____

- **Enter the entire name of the facility where the first positive HIV test was collected. Include the city and state/country of the facility.**
- **The facility of <u>first</u> diagnosis may be different from the facility where the form is being completed.**
- **Indicate if the facility is public, private, federal, or you do not know.**
- **Indicate the facility type.**



V. PATIENT HISTORY

AFTER 1977, AND PRECEDING THE FIRST POSITIVE DIAGNOSIS FOR HIV INFECTION OR AIDS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (Specify): _____

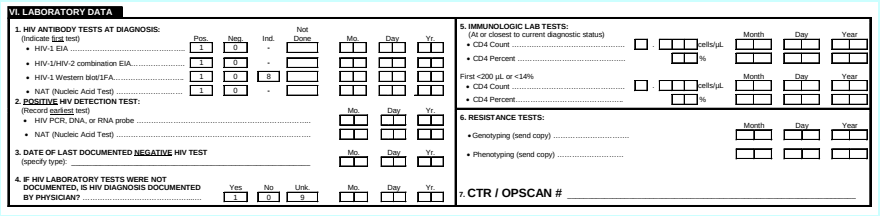
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9

First Mo. Yr. Last Mo. Yr.

• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting (specify occupation): _____	1	0	9

- **Patient History is important in determining a person's probable source of exposure to HIV.**
- **Indicate <u>yes, no, or unknown</u> for all bullet points. Ask the person, do not guess.**

- **Indicate the type of test used for diagnosis; the result; and the month, day, and year of the test. There must be a positive Western Blot (WB) or physician's diagnosis for an HIV diagnosis.**
- **If there is only a positive EIA/ELISA with a negative or indeterminate WB and NO physician's diagnosis, DO NOT complete a case report form. Depending on risky behavior, offer an appropriate retesting timeframe for a negative WB. A WB that is indeterminate should always have a repeat test done.**
- **Indicate the date of the last negative HIV test.**
- **If a physician wants to document an HIV diagnosis without test results to back the diagnosis, he/she must indicate the month, day, and year that the diagnosis was determined. Indicate in the comment section why the diagnosis is being made.**
- **Indicate CD4 results and genotype/phenotype information in the appropriate boxes.**
- **Counseling and Testing Sites: You must indicate the CTR/OPSCAN Number on line #7.**



VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos.	Neg.	Ind.	Not Done	Mo.	Day	Yr.
• HIV-1 EIA	1	0	-				
• HIV-1/HIV-2 combination EIA	1	0	-				
• HIV-1 Western blot/1FA	1	0	8				
• NAT (Nucleic Acid Test)	1	0	-				

2. POSITIVE HIV DETECTION TEST: (Record earliest test)

	Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe			
• NAT (Nucleic Acid Test)			

3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (specify type): _____

Mo.	Day	Yr.

4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes 1 / No 0 / Unk. 9

Mo.	Day	Yr.

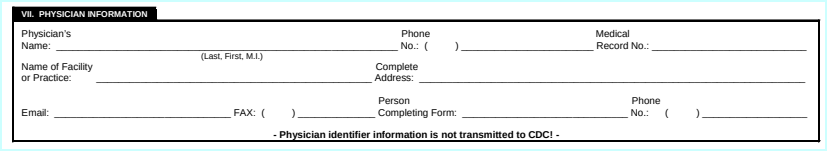
5. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

	Month	Day	Year
• CD4 Count ☐ . ☐☐☐ cells/µL			
• CD4 Percent ☐☐ %			
First <200 µL or <14%			
• CD4 Count ☐ . ☐☐☐ cells/µL			
• CD4 Percent ☐☐ %			

6. RESISTANCE TESTS:

	Month	Day	Year
• Genotyping (send copy)			
• Phenotyping (send copy)			

7. CTR / OPSCAN # _____



VII. PHYSICIAN INFORMATION

Physician's Name: _____ (Last, First, M.I.) Phone No.: ( ) _____ Medical Record No.: _____

Name of Facility or Practice: _____ Complete Address: _____

Email: _____ FAX: ( ) _____ Person Completing Form: _____ Phone No.: ( ) _____

- Physician identifier information is not transmitted to CDC! -

- **Legibly print the physician's first name and last name and the phone number where the physician can be reached.**
- **Please include the medical record number, if available.**
- **Indicate the Hospital/Facility where the patient/client is receiving care at the time the form is completed. Indicate the email address and fax number of the facility.**
- **Indicate legibly the first name and last name of the person completing this form and the phone number where they can be reached.**

VIII. VIRAL LOAD DATA*

Laboratory Name: _____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date _____/_____/_____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date _____/_____/_____

- **Indicate the laboratory that ran the viral load test. Mark the type of test run, the result, and the date the blood was drawn/collected.**

- **Information listed here will define an AIDS diagnosis.**
- **Be sure of the diagnosis and the date of diagnosis. Be certain there is a definitive diagnosis for those that do not allow a presumptive diagnosis.**

IX. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

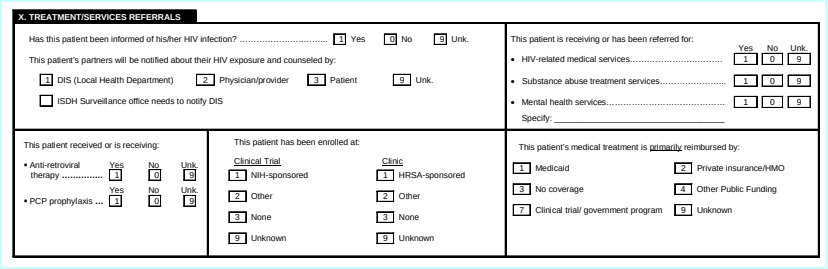
ENTER DATE PATIENT WAS DIAGNOSED AS: ASYMPTOMATIC (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo ___ Day ___ Yr. ___ Symptomatic (not AIDS): Mo ___ Day ___ Yr. ___

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Day	Initial Date Yr.
1) Candidiasis, bronchi, trachea, or lungs	1	NA			
2) Candidiasis, esophageal	1	2			
3) Carcinoma, invasive cervical	1	NA			
4) Coccidioidomycosis, disseminated or .extrapulmonary	1	NA			
5) Cryptococcosis, extrapulmonary	1	NA			
6) Cryptosporidiosis, chronic intestinal (>1 Mo. duration)	1	NA			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			
8) Cytomegalovirus retinitis (with loss of vision)	1	2			
9) HIV encephalopathy	1	NA			
10) Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			
11) Histoplasmosis, disseminated or extra pulmonary	1	NA			
12) Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			
13) Kaposi's sarcoma	1	2			
14) Lymphoma, Burkitt's (or equivalent term)	1	NA			
15) Lymphoma, immunoblastic (or equivalent term)	1	NA			
16) Lymphoma, primary in brain	1	NA			
17) *Mycobacterium avium* complex or M. Kansasii, disseminated or extrapulmonary	1	2			
18) *M. tuberculosis, pulmonary**	1	2			
19) *M. tuberculosis*, disseminated or extrapulmonary*	1	2			
20) *Mycobacterium*, of other species or unidentified species,disseminated or extrapulmonary	1	2			
21) *Pneumocystis carinii* pneumonia	1	2			
22) *Pneumonia*, recurrent, in 12 mo. period	1	2			
23) Progressive multifocal leukoencephalopathy	1	NA			
24) Salmonella septicemia, recurrent	1	NA			
25) Toxoplasmosis of brain	1	2			
26) Wasting syndrome due to HIV	1	NA			

Def. = definitive diagnosis Pres. = presumptive diagnosis

*RVCT CASE NO.: _____

• **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown



X. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? ..... [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:

[1] DIS (Local Health Department) [2] Physician/provider [3] Patient [9] Unk.

[ ] ISDH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

	Yes	No	Unk.
• HIV-related medical services.....	1	0	9
• Substance abuse treatment services.....	1	0	9
• Mental health services.....	1	0	9

Specify: _____

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	1	0	9
• PCP prophylaxis ...	1	0	9

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:

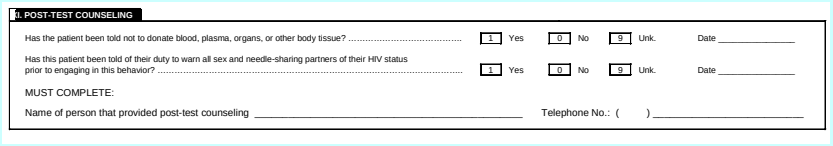
[1] Medicaid [2] Private insurance/HMO

[3] No coverage [4] Other Public Funding

[7] Clinical trial/ government program [9] Unknown

- **Indicate if the person has been informed of his/her diagnosis.**
- **Indicate who will notify partners.**
- **Specify Mental Health Service referrals. Indicate for what purpose: specify bipolar, schizophrenia, paranoia, depression, non-injection drug use, alcohol abuse, suicidal tendencies, etc.**
- **Complete all sections regarding treatment accurately and completely.**

- **The person providing the positive test result MUST post-test counsel the patient. This MUST include informing him/her that there are laws that say they may not donate blood, plasma, organs or tissue, AND that they MUST inform all sex and needle sharing partners BEFORE they engage in any sexual or needle sharing acts. However, it is important that ALL subsequent health care providers reinforce this point and document it in their medical records.**
- **Indicate the first and last name of the person who did the post-test counseling and the phone number where they can be reached.**



Y. POST-TEST COUNSELING

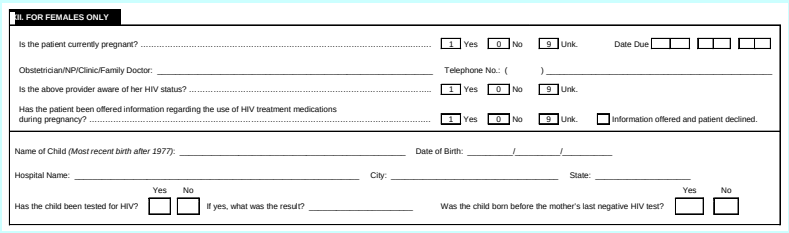
Has the patient been told not to donate blood, plasma, organs, or other body tissue? ..... [1] Yes [0] No [9] Unk. Date _____

Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior? ..... [1] Yes [0] No [9] Unk. Date _____

MUST COMPLETE:

Name of person that provided post-test counseling _____ Telephone No.: ( ) _____

COMPLETE THIS SECTION FOR ALL FEMALES



II. FOR FEMALES ONLY

Is the patient currently pregnant? ..... 1 Yes 0 No 9 Unk. Date Due ___/___/___

Obstetrician/NP/Clinic/Family Doctor: _____ Telephone No.: ( ) _____

Is the above provider aware of her HIV status? ..... 1 Yes 0 No 9 Unk.

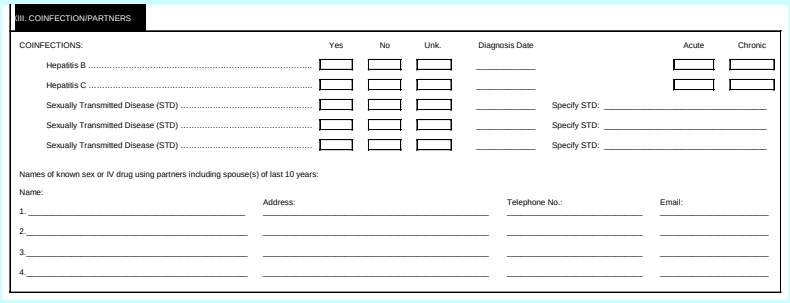
Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ..... 1 Yes 0 No 9 Unk. ☐ Information offered and patient declined.

Name of Child *(Most recent birth after 1977)*: _____ Date of Birth: ____/____/____

Hospital Name: _____ City: _____ State: _____

Has the child been tested for HIV? Yes ☐ No ☐ If yes, what was the result? _____ Was the child born before the mother's last negative HIV test? Yes ☐ No ☐

- **Indicate if the patient is currently pregnant.**
- **Enter the date of expected delivery.**
- **Indicate the name and phone number of the health care provider for this pregnancy.**
- **Indicate if the health care provider is or is not aware of the patient's HIV status.**
- **Indicate if the patient has received information on antiretroviral medications in relationship to pregnancy. Indicate if she declined medications.**
- **List the name of the most recent birth since 1977 and his/her birth date.**
- **Indicate the name of the hospital, city, and state where the child was born. Has the child been tested? List the result. Indicate if this child was born before the mother's last negative test.**



III. COINFECTION/PARTNERS

COINFECTIONS:	Yes	No	Unk.	Diagnosis Date		Acute	Chronic
Hepatitis B	☐	☐	☐	_____		☐	☐
Hepatitis C	☐	☐	☐	_____		☐	☐
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____		
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____		
Sexually Transmitted Disease (STD)	☐	☐	☐	_____	Specify STD: _____		

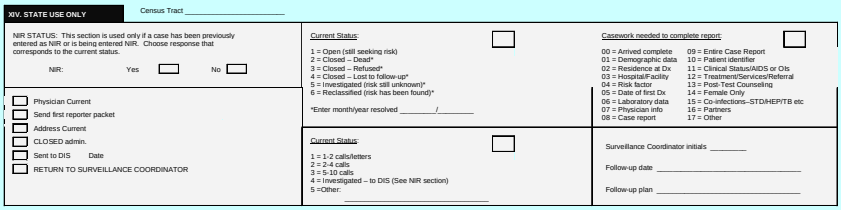
Names of known sex or IV drug using partners including spouse(s) of last 10 years:

Name:	Address:	Telephone No.:	Email:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

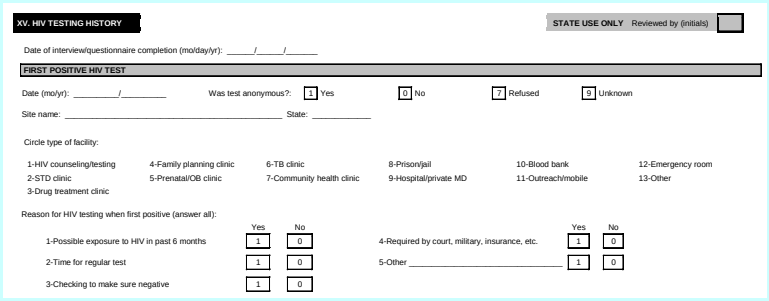
- **List Co-infections:**
  Indicate if the person has had a Hepatitis B and/or C diagnosis: Indicate the date of diagnosis. Was it an acute or chronic case?
  Sexually Transmitted Disease (STD): Specify which STD (chlamydia, gonorrhea, syphilis, HPV, herpes, other) and the date of diagnosis.

- **Partners:**
  List sex and needle sharing partners for the last year and spouses for the last 10 years for those persons you need help from ISDH to notify.

XIV. State Use Only

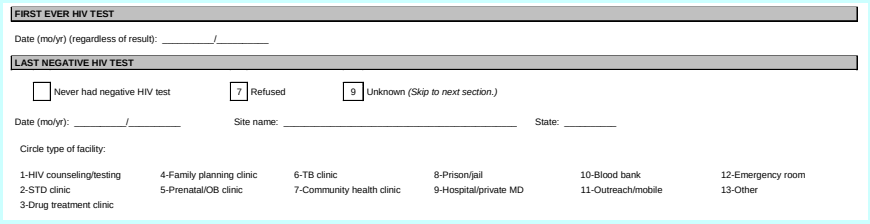


XV. HIV TESTING HISTORY



First Positive HIV Test

- Enter the month, day and year you are completing the testing history.
- Enter month and year of first Western Blot positive HIV test *(Note: This may be the current test you are reporting, or a previous positive test. If the individual reports a previous Western Blot positive test, that test should be referenced for the remainder of the questions, not the current positive test.)*
- Place an "X" over yes, no, refused, or unknown to indicate whether the first positive test was anonymous.
- Enter the name of the site where the individual first tested positive *(e.g., Dr. Joe Smith),* and enter the State where the individual first tested positive *(e.g., Indiana).*
- Circle the number 1-13 of the facility type that corresponds to the site listed above (*e.g., 9-Hospital/private MD)*
- Mark Yes or No for EACH of the five (5) possible reasons the individual got tested when he/she first tested positive. If "Other" is marked yes, please provide a reason.



FIRST EVER HIV TEST

Date (mo/yr) (regardless of result): _____/_____

LAST NEGATIVE HIV TEST

☐ Never had negative HIV test ☐ 7 Refused ☐ 9 Unknown *(Skip to next section.)*

Date (mo/yr): _____/_____ Site name: _____ State: _____

Circle type of facility:

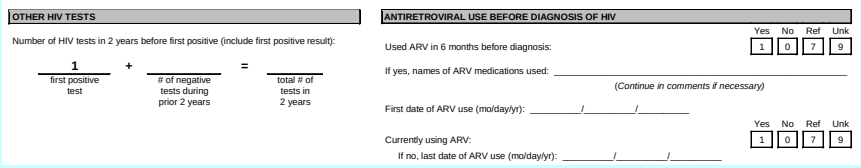
1-HIV counseling/testing	4-Family planning clinic	6-TB clinic	8-Prison/jail	10-Blood bank	12-Emergency room
2-STD clinic	5-Prenatal/OB clinic	7-Community health clinic	9-Hospital/private MD	11-Outreach/mobile	13-Other
3-Drug treatment clinic					

First Ever HIV Test

- Enter the month and year the individual first got tested for HIV *(Regardless of result)*

Last Negative HIV Test

- Place an "X" in the first box if the individual has NEVER had a negative HIV test result. Place an "X" in the Refused or Unknown box if appropriate. *(Note: If the individual has never had a negative HIV test result, refuses, or is unknown then skip the rest of this section only)*
- Enter the month and year the individual last tested negative for HIV**.**
- Enter the name of the site where the individual first tested positive *(e.g., Dr. Joe Smith);* and, enter the state where the individual first tested positive (*e.g., Indiana).*
- Circle the number 1-13 of the facility type that corresponds to the site listed above *(e.g., 9-Hospital/private MD).*



OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1 (first positive test) + (# of negative tests during prior 2 years) = (total # of tests in 2 years)

ANTIRETROVIRAL USE BEFORE DIAGNOSIS OF HIV

	Yes	No	Ref	Unk
Used ARV in 6 months before diagnosis:	1	0	7	9

If yes, names of ARV medications used: _____

(*Continue in comments if necessary)*

First date of ARV use (mo/day/yr): _____/_____/_____

	Yes	No	Ref	Unk
Currently using ARV:	1	0	7	9

If no, last date of ARV use (mo/day/yr): _____/_____/_____

Other HIV Tests

- Enter the total number of HIV tests the individual had in the two (2) years prior to his/her first Western Blot positive test result.

Antiretroviral Use Before Diagnosis of HIV

- Place an "X" in the appropriate box (Yes, No, Refused, Unknown) for whether the individual has used Antiretroviral (ARV) medications in the past six (6) months.
- List the Antiretroviral (ARV) medications the individual has used, if the answer to the previous question is Yes.
- List the month, day, and year the individual first starting taking the Antiretroviral (ARV) medications.
- Place an "X" in the appropriate box (Yes, No, Refused, Unknown) for whether the individual is currently using Antiretroviral (ARV) medications.
- List the month, day, and year the individual last used Antiretroviral (ARV) medications, if he/she is not currently using ARV.

COMMENTS:

(Attach additional sheet if needed.)

COMMENTS

- **Use this section for any other pertinent information such as:**
  Has spouse/partner been tested or reported?
  Has patient been referred to care coordination? If so, coordinator's name, location and phone number.
  Is patient from another state/country? If so, were they diagnosed there?
  Are there any reported symptoms, such as previous pneumonia, cancer, etc.?
  If patient has children, have they been tested? If positive, have they been reported?
  Expected date of release from jail or prison.
  List any other miscellaneous information you feel may be useful.

If you are aware of an HIV-positive child under 13 years of age and/or a woman with HIV that just delivered, contact your surveillance department for assistance in completing the appropriate forms.

NOTE: **Additional case report forms and other reporting information can be obtained from the ISDH Web site at:**

www.statehealth.in.gov/programs/hivstd/index.htm

Then, click on Confidential Case Report Forms and then the Adult Case Report Form; print.

Mailing labels can also be obtained by calling (800) 376-2501.

Surveillance Contacts

Lake County - **(219) 755-3030**
Marion County - **(317) 221-2132**
All other counties, **call ISDH Surveillance toll free (800) 376-2501**